CALIFORNIA'S HEALTH

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DIRECTOR OF PUBLIC HEALTH

STATE DEPARTMENT OF PUBLIC HEALTH
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PARTICIPATION OF LOCAL FULL-TIME HEALTH DEPARTMENTS IN SCHOOL HEALTH PROGRAMS IN CALIFORNIA

V. (A) NURSING ACTIVITIES*

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The nurse, since her entry into the schools nearly forty years ago, has contributed much to the development of school health programs. She has assisted the physician, been a friend to the pupils, an advisor to the teacher and principal, and a source of health information for parents.[1]

The nurse is the center and focal point of the integration of many facets of the school health program. It is she who works most directly with children, parents, teachers, school administrators, health officers, physicians, dentists and social workers in developing and integrating programs of improved health care for children. The type, quality and extent of her services often spell the difference between the success or failure of much of the school health program.

The functions of nurses in schools have undergone change as public health programs have evolved. From her position as inspector for signs of illness or defect in children and a dispenser of first aid she has grown to the position of health consultant to teachers, parents and children, helping them in the solution of the child's health problems. Instead of serving as the individual who performs all of the routine minor services necessitated by the advent of disease or accident, she helps others to see their important responsibilities and contributions to school health and aids them in developing methods of attaining them.

In general, essential nursing services in schools may be stated as:

1. Giving advisory service to school administrators with reference to the school health program. This should include guidance with regard to fuller use of all community health and welfare facilities.
2. Instructing teachers, individually and in groups, concerning health services they are to perform.
3. Interpretation of health examinations to teachers, parents and children as indicated, including advisory service in utilizing all community resources to make these examinations productive.
4. Visiting homes for the purpose of interpreting the needs of the child to parents, to learn family health problems for interpretation to the school, and to assist both the family and the school in the solution of these problems. [2]

The nurse who accomplished these purposes will not spend her entire working day in the school building. It is her job to work with the school child in his total environment of home, school and community. "The nurse sees the child, not in a vacuum, but as a part of his whole environment, especially his home and family." [3]

The public health nurse employed by the health department has greater opportunity for the rendition of this type of service to the school child then does the nurse employed by the school. She already has responsibilities for family consultation concerning health problems of the pregnant mother, the infant and preschool child, the tuberculous grandmother, the syphilitic father, and she is in a position to deal with the

* Sixth in a series of excerpts from a doctoral dissertation on file in Stanford University Library.

[1] Joint Committee on Health Problems in Education, of the National Education Association and the American Medical Association, *The Nurse in School*, National Education Association, Washington, 1940. Foreword.

[2] Bosse B. Randall, "Wartime Essentials in School Nursing," *Public Health Nursing* XXXV, September, 1943, p. 482.

[3] Editorial, "School Nursing in These Times," *Public Health Nursing* XXXIII, September, 1941, p. 501.

health problems of the school child within the matrix of the family situation. The school nurse, on the other hand, limits her service to one segment of the population for eight or nine months of the year and is more likely to see her job as something a bit remote from homes and families. That many nurses working exclusively in schools do overcome this barrier is credit to their vision and resourcefulness.

The public health nurse in the health department who has responsibility for school work must sometimes face the barrier of being an outsider as far as school faculties are concerned. Her functions may not be understood or accepted by school personnel and schools may not feel that they should include her in their planning because they do not pay her salary.

> School nursing conducted on a generalized basis very definitely places the nurse in the position of serving several masters whose interests and methods of procedure may conflict. [4]

A common source of misunderstanding and conflict is found in the varying concepts which school administrators and public health officials have concerning the functions of the nurse. The school faculty often wants a nurse available at all times to render first aid to children, handle emergency illness, transport sick children to their homes, conduct inspections for illness and defects on a mass basis, weigh and measure children, and similar duties so that teachers will be relieved of such responsibilities. The principal may think of her as an attendance officer and give her the responsibility of checking on all absentees, rather than limiting such duties to those children who are absent because of illness. When her time is consumed with routine activities of this nature she has little or no time to render health consultation service to families or to work with community agencies for the improved health care of school children.

> The public health nurse is not a certified teacher and should not be expected to teach in the schools, nor should she spend too much of her time in the schools. She is the most important link between the school, the home, and the community. It is a waste of taxpayers' money and an imposition on an already over-crowded health service to require public health nurses to remain in the schools waiting to give first aid. [5]

ROLE OF THE TEACHER

In recent years there has been a growing emphasis on the role of the teacher in performing many of the functions often considered to be the province of the nurse. The teacher, through her daily contacts with her pupils has an opportunity to note changes in behavior and appearance which are indicative of the presence of health problems. She is not in a position to diagnose, nor is the nurse, but she can refer her suspicions concerning bodily malfunction or personality upset to the nurse, physician or family of the child and further investigation of the conditions can be instituted. Further than this, the teacher who participates in health observations of her children becomes more keenly interested in their health problems. When she discovers from a child's weight record that he has failed to gain over a period of weeks or months she becomes concerned about that child and what can be done for him. If she gives a vision test and discovers that her poor reader cannot see the chart, she immediately tries to find a means of finding a remedy to the situation. Her sharpened interest in health is more likely to be translated into better health instruction and guidance for her children.

> The chief argument for teachers giving these tests (vision tests) and other similar routine health tests is the fact that in this way they can become a part of the health educational program; that their daily observations of the children's behavior and appearance are likely to be sharpened by seeing them repeated in the test situation. The test, itself, then becomes a subject for health education study. The nurse becomes a consultant to the teachers in planning this program and in carrying it through. [6]

Teachers have proved their ability to observe and identify children with health problems. In a study conducted by Ben Miller, on the effectiveness of the teacher in the physical inspection of the public school child, it was found that the teacher made valid judgments on 36 validated items of the physical inspection. "She did a commendable job in terms of efficiency (segregating deviations), accuracy (recognizing normal conditions), and effectiveness (making total judgments), regardless of the items inspected or the degree of discrimination requested." [7] These findings have been corroborated in other studies and in actual practices in school situations.

The Astoria School Health Study is outstanding because of its development of techniques which pooled the observations of teachers and nurses in selecting the children for medical examination. Teachers were provided with a health card for each pupil in their groups, upon which they recorded height, weight, results of the Snellen vision test, observations of obvious dental decay, a record of absences for illness, and symptoms of abnormal functioning of eyes, ears, nose and throat,

[4] Mellie F. Palmer, "The Supervision of School Nursing," *Public Health Nursing*, XXXII, January, 1940, p. 48.
[5] Report of the American Public Health Association, *The Health Situation in Florida*, State Department of Health, Jacksonville, Florida, 1939, p. 53.
[6] Eleanor W. Mumford, "Sharing the Eye Health Program with Teacher," *Public Health Nursing*, XXXV, September, 1943, p. 504.
[7] Ben W. Miller, "A Critical Evaluation of the Effectiveness of the Teacher in the Physical Inspection of Public School Children," *The Research Quarterly*, XIV, May, 1943, p. 136.

general condition and appearance, and behavior.[8] The teacher collected this information and brought it to the attention of the nurse at regularly scheduled nurse-teacher conferences.

The data from the Pupil Health Card and Medical Card for each child, plus the interchange of questions and information between nurse and teacher, were employed as a basis of selection and it was possible also to distinguish the type of examination in each case—whether a rapid inspection or a longer examination was needed. A check study showed that eight out of ten children selected by the nurse and teacher had a health problem and that few children needing medical attention were overlooked.[9]

Teachers are partners with nurses and physicians in such a health program and have a keen satisfaction when they contribute to the solution of a child's health or adjustment problem. They should be kept informed of the further activities for the children they help to bring to the attention of nurses, physicians and parents, and nurses have a responsibility to complete the cycle and bring back to the teacher a report of the follow-up activities and the knowledge of the child's home condition. The nurse-teacher team is rapidly becoming recognized as the most effective method of identifying the health problems of school children.

In order that this desirable cooperative activity may function successfully in the schools, it is necessary that nurses and teachers understand their respective responsibilities and mutually agree to a cooperative program to execute them. The development of a statement of policy in this regard as a cooperative activity, is a constructive approach to the problem.

If teachers are going to successfully conduct programs of health observations of children they will need instruction and supervision in the initial stages. The nurse has an important function to perform in this regard, and should devote time to meeting with teachers individually and in groups, and helping them to gain understanding and skill in testing and observing children. If the teacher feels that she is just taking on an extra duty which is burdensome, in order to save the nurse from work, she will be resentful and uncooperative. If she sees her activities as a real contribution to the improvement of a child's physical, social and educational adjustment and progress which only she can make, then she is more likely to accept her responsibilities and discharge them willingly.

SPECIFIC FUNCTIONS

The more specific school health functions of public health nurses employed by health departments who carry generalized public health nursing programs, and who render school services as a phase of the generalized program include:

1. Conferences with teachers concerning children, to identify those children having significant health problems.
2. Instruction and demonstrations for teachers on methods and techniques of health observation and testing of children.
3. Conferences with and more thorough inspections of children whom teachers have identified as having significant health problems.
4. Follow-up procedures to secure examination and diagnosis of children with suspected health defects through:
   a. Consultation with parents and encouragement of examination by private physicians.
   b. Arrangement for their examination in school or health clinic programs.
5. Assisting the physician with school health examinations and immunizations.
6. Keeping health records of school children up-to-date and transmitting significant information concerning the children to appropriate school personnel.
7. Working with parents in the arrangement for medical and dental care as needed, and in the improvement of the child's daily health routine.
8. Working with social welfare agencies and other community or governmental organizations to secure health services for children from low-income and indigent families.
9. Investigation of cases of illness of children and reporting suspected communicable diseases to the health department.
10. Observing conditions of poor sanitation in schools and working with school administrators, teachers and health department sanitarians to bring about improvements in the school environment.
11. Recommending health teaching materials and consulting with teachers concerning their health instruction programs.
12. Service on joint committees of health department and school personnel to develop and clarify policies and programs.
13. Supervision of the health features of the school program of the physically handicapped child.
14. Helping schools to work out programs for the care of emergency illness and acidents.

SURVEY OF NURSING ACTIVITIES

The survey of school nursing activities of health departments in California indicates wide and varied participation in school programs. The trend is in the direction of participation in services in line with the present philosophy concerning the functions of nurses in schools, but the transition between the older and newer philosophy is still in progress.

[8] Nyswander, *Solving School Health Problems*, op. cit. pp. 62-65.
[9] Ibid, p. 30.

TABLE 1

Nurses Employed by Health Departments and by Schools in Cities and Counties in California Which Are Served by Full Time Health Departments, June, 1945

Health department	Public health nurses under health dept. supervision	Public health nurses with school duties	Registered nurses under health dept. supervision	Registered nurses with school duties	School nurses not under health dept. supervision	PHN supervisor
I. City Health Departments						
Berkeley	12	12			0	x
Fresno	4½	3	½		10	
Long Beach	0	0	5	0	8	
Los Angeles	92	49	39	1	167	x
Oakland	22	as assigned	5		32	x
Palo Alto	3	3	0	0	0	
Pasadena	7	0			7	x
Richmond	12	0			8	x
Sacramento	3	3	2	2	10	x
San Jose	15	14	1			x
Santa Barbara	1	0	4	1	5	
Totals	171½	84	56½	4	247	7
II. County Health Departments						
Alameda	10	10	5	5	4	x
Contra Costa	8	7			8	x
Imperial	1	1	3	3	1	
Kern	20	15			7	x
Los Angeles	73	0	23	0	114	x
Madera	2	2			2	
Marin	6	6			6	x
Monterey	10	8			5	x
Orange	16	14				x
Riverside	14	9	1	1	9	x
Sacramento	6	6			1	x
San Bernardino	15	12	4	1	9	x
San Diego	26	26	8	8	?	x
San Francisco	78	56	9	0		x
San Joaquin	15	12	3	1		x
San Luis Obispo	7	7			4	x
Santa Barbara	11	11	½		1	x
Santa Clara	7½	7½			9	x
Santa Cruz	2	2			3	x
Solano-Vallejo	7	2	2	0	5	x
Sonoma	6	5			5	x
Stanislaus	5	5	5	3		x
Sutter	3	3			1	x
Tulare	8	7	1	0	8	x
Ventura	6	6	1	1	9	x
Yolo	4	4			1	x
Yuba	3	3	1	1	1	x
Totals	369½	246½	66½	24	213	25

The situation in California with respect to the employment of nurses by health departments and by schools in areas served by health departments is shown in Table 1. The figures reflect wartime conditions, inasmuch as the replies to the questionnaire were received between April and June, 1945. Many health departments at that time had vacancies in their staffs, which they could not fill because personnel were not available. Registered nurses without additional training in public health were recruited for some of these positions and were serving on an emergency basis. Training of this latter group in public health philosophy, program and techniques while on the job, created additional work for public health nursing supervisors.

As can be seen by the table, health department nurses have more responsibilities for school service in the counties than in the cities. In the cities only 88 of the total of 228 that were employed, had school health responsibilties, while there were 247 nurses employed by schools for school service exclusively. In the counties, however, practically all health department nurses carried school programs as a part of their total program. With the exception of Los Angeles County where nurses are employed directly by schools there were only 50 health department nurses who did not serve schools. If the Los Angeles figures are subtracted from the totals it is seen that in all other counties there were 270½ health department nurses serving schools as contrasted with 99 nurses employed directly by schools. With the Los Angeles totals included, there were 213 nurses employed by schools for school work

TABLE II

Schools Having Nursing Services in Cities and Counties in California Which Are Served by Full Time Health Departments

Health department	High schools served by health dept. nurses	High schools served by school nurses	High schools having no nurse supervision	Ele. schools served by health dept. nurses	Ele. schools served by school dept. nurses	Ele. schools having no nurse supervision
I. City Health Departments						
Berkeley	3	0	0	16	0	0
Fresno	0	8	0	3 par.	19	0
Long Beach	0	all	0	0	all	0
Los Angeles	5 par.	all pub.	0	49 par.	all	0
Oakland	nr	all pub.		nr	all	
Palo Alto	2	0	0	8	0	0
Pasadena	0	all	0	0	all	0
Richmond	0	nr		0	nr	
Sacramento	3 par.	2 pub.	0	8 par.	18 pub.	
San Jose	4	0	0	16	0	0
Santa Barbara	1 par.	3 pub.	0	3 par.	8	0
II. County Health Departments						
Alameda	0	2	3	34	nr	0
Contra Costa	3	5	0	37	6	0
Imperial	2	1	3	all		
Kern	5	7	0	86	5	0
Los Angeles	0	nr	nr	0	nr	nr
Madera	3	0	0	34	8	0
Marin	1	nr		all (Limited)		
Monterey	0	2	4	57	1	0
Orange	4	4	4	all		
Riverside	6	6	1	30	?	
Sacramento	6	1	0	57	3	0
San Bernardino	4	3	0	65	42	0
San Diego	8	1	1	70	nr	0
San Francisco	23	0	5 par.	142	0	0
San Joaquin	nr	nr	nr	116	0	0
San Luis Obispo	6	2	0	37	13	0
Santa Barbara	3	1	0	50	0	0
Santa Clara	0	5	0	35	11	0
Santa Cruz	2	2	0	44	10	0
Solano-Vallejo	0	7	nr	?	33	
Sonoma	2	7	0	?	?	0
Stanislaus	7	nr	0	57	0	0
Sutter	3	1	0	23	0	0
Tulare	2	6	0	88	17	2
Ventura	3	4	0	27	26	0
Yolo	5	1	0	38	3	0
Yuba	1	1	0	25	0	0

par. = Parochial
pub. = Public
nr = not reported
? = report not clear

in the counties as against the 270½ health department nurses.

The quality and type of relationships existing between health department and school nurses is important in the total program of school health. In some situations there is little or no contact between the two groups. In others, they exchange information on cases they discover which are in the jurisdiction of the other group, join in professional meetings and work together on various phases of the program. Supervisory personnel in both health departments and schools need to give attention to plans for unifying the efforts of nurses serving the schools in adjacent or overlapping areas, in the interest of a better total program. Fourteen of the health departments reported that there was someone in the schools in their city or county, responsible for school health supervision or coordination, and 32 of the 38 health departments employ public health nursing supervisors, so it is evident that there is a nucleus of supervisory personnel already existing that could develop better coordination practices.

The information summarized in Table 2 was sought in an effort to discover what the situation is in regard to coverage of high schools as compared with elementary schools. The replies on this point were not complete, nor entirely clear, but the information obtained indicates that in counties, health department nurses serve a greater percentage of elementary schools than high schools, and that there are more high schools without nursing supervision than elementary schools. In the county health departments (excluding San Francisco) there were almost as many high schools which employed their own nurses as there were high schools under health department supervision—69 as against

72—while the total number of elementary schools supervised by health departments was far greater than the number under school department supervision. This confirms the often observed fact that health departments more frequently render services to elementary schools than to high schools, largely because high school districts usually have the funds and prefer to independently organize their own services.

An attempt was made to discover the kinds of services health department nurses render to the schools they serve. The activities of nurses have been classified for this purpose into the following categories: (1) activities relating to the control of communicable diseases, (2) the care of emergency illness and accident, (3) activities concerned with the discovery of children with physical defects, (4) assistance with physical examinations and immunizations, including record keeping, (5) follow-up contacts in homes and communities, (6) checking environmental conditions unfavorable to health, and (7) consultation with teachers concerning health education

NOTE.—The second portion of Installment V will be printed in the next issue.

STUDY SHOWS CALIFORNIA HOSPITAL COSTS HIGHEST IN NATION

A survey reported in the September issue of *Hospitals* [1] shows California nonprofit general and special civilian short term hospitals leading those of all other states in total expenditures per patient day.

Estimated at $12.87 per patient day, total expenditures by California hospitals of this type are considerably higher than the national average which is estimated at $8.95 per patient day.

Californians pay a greater percentage of their hospital care costs than the people of any other state. Of the $12.87 which the hospital must expend per patient day, approximately 94 per cent ($12.16) comes directly from the patient. Figures which reflect the national average show payments from patients account for 89 per cent of total hospital expenditure per patient day in the nation as a whole.

Ranking behind this State, Michigan's total hospital expenditures are estimated to be $11.10 per patient day. Rhode Island is third with $10.55.

The report from which these data are taken was made in connection with the preparation of the 1946 edition of the American Hospital Directory. Information was obtained by a questionnaire to which institutions representing approximately two-thirds of the total bed capacity in registered nonprofit short term general and special civilian hospitals replied.

[1] Hudenberg, Roy "Patients Pay $1 Day Below Costs." *Hospitals*, XX, September 1946. p. 51.

SAN DIEGO LEADS CITIES IN TRAFFIC RECORD IMPROVEMENT

San Diego led all other United States cities of 250,000 or more population in improvement of its traffic death record for the first eight months of 1946 as compared with a similar period in 1945, according to figures released by the National Safety Council in the October issue of *Public Safety*.

The southern city bettered its 1945 record by 45 per cent, reducing the number of traffic deaths from 64 in the first eight months of 1945 to 34 in an identical period this year.

San Leandro, California, took honors among the smaller cities (10,000 to 25,000 population) for the first eight months of 1946 by establishing a record of *no* traffic deaths for that period. Nineteen hundred forty-six was the second consecutive year that this community succeeded in keeping its traffic record spotless for the eight month period January to August.

Other California cities to show improvement in 1946 records over those of 1945 were: Oakland, Berkeley, Glendale, Santa Monica, Riverside and Palo Alto.

California as a whole, however, did not fare as well as some of its cities. Deaths due to motor vehicle accidents were up 17 per cent over the 1945 figure and 10 per cent above the 1941 mark for the first eight months of the year.

The national traffic death toll for the first seven months of the year was 34 per cent above that of the same period in 1945, although it is 12 per cent below the 1941 figure.

National statistics of traffic deaths for the month of August also showed a substantial decrease (24 per cent) over the same month in 1941—the year of an all-time high in traffic deaths. August was the fourth consecutive month of substantial reductions over 1941 traffic death figures.

NORTHERN COUNTIES DEVELOP MENTAL HYGIENE PROGRAMS

The Northern California Mental Hygiene Society reports the development of programs in eight Northern California counties. These counties are: Alameda, Kern, Marin, Monterey, Sacramento, San Joaquin and Sonoma.

Local activities for this year have featured forum discussions, radio programs, monthly lectures, and special talks.

California was one of nine states whose accidental death rate was over 90 deaths per 100,000 population in 1945.

PRENATAL AND PREMARITAL BLOOD TEST REGULATIONS AMENDED

Regulations of the State Board of Health concerning the performance of premarital and prenatal serological tests for syphilis have been greatly strengthened by amendments adopted by the Board November 4, 1946.

In the future, laboratories will not be approved to do prenatal and premarital tests "if they advertise the performance of these tests in magazines, newspapers, directories, circulars, etc., commonly read by the lay public."

Other of the new amendments include requirements that laboratories submit to check tests; stipulation of the kind of license which must be held by a person who performs prenatal and premarital tests; and the elimination of provisions for a single test.

Copies of the new regulations are being printed and will soon be ready for distribution. The requirements now read as follows:

TITLE 17. CHAPTER 2, SUBCHAPTER 1, GROUP 4, ARTICLE 1

SECTION 1125. Any laboratory that desires to make serological tests for syphilis under the provisions of Act 6265, (1939) General Laws of California and Article IIa, Chapter I, Title 1, Part III Division First of the Civil Code shall first apply to the State Division of Laboratories for the requisite forms and instructions and it shall at the same time transmit a statement in detail of the method of performing the tests that will be used.

SECTION 1126. A standard or approved serological test as referred to in the Premarital and Prenatal Laws shall consist of the application to each specimen of a combination of any two of the following precipitation tests,—Kahn, Kline, Mazzini, Eagle or Hinton, or one of the above precipitation tests, and any one of the following complement fixation tests,—Kolmer, or Eagle, provided, however, that as an alternative any other test not listed herein may be used in lieu of one of the listed tests when the substitution is especially approved by the Department and provided further that upon specific authorization of the department a single screen test procedure may be applied. Substitution of a test for one of the tests listed on the application to perform premarital and prenatal tests shall not be made until approval for such change is obtained in writing from the Division of Laboratories. All equipment recommended by the author of the test must be available in the laboratory before approval can be granted.

SECTION 1127. All tests shall be conducted in strict conformity with the published technique of the author without any change and where a given test has been modified by its author any modification published within the five years preceding the date of these regulations must be used.

SECTION 1128. Any laboratory approved to perform premarital and prenatal serology tests shall agree to accept check specimens periodically from the Division of Laboratories for evaluation purposes. If the check tests reveal undependable serological tests the laboratory in question shall make changes as recommended by the Division of Laboratories to insure dependable serological tests or return all forms and discontinue the testing of serums under the premarital and prenatal laws of California.

SECTION 1129. Laboratory report forms and marriage health certificates are not transferrable from one laboratory (to which they are assigned) or to a branch laboratory. The above forms and certificates must not be transmitted to the physician until the tests have been performed.

SECTION 1130. Only those persons who are in possession of a license as physician and surgeon, a clinical laboratory technologist, or a clinical laboratory technician, or a certificate as a public health laboratory technician shall be permitted to conduct premarital and prenatal serologic tests for syphilis.

SECTION 1131. Whenever new personnel are employed to perform prenatal or premarital serology tests the names of the new employees shall be transmitted within 30 days to the Division of Laboratories. This rule does not apply to the rotation of staff members from one phase of laboratory work to another.

SECTION 1132. Changes in the director or in the location of the laboratory will require a new application for approval to do premarital and prenatal serology tests.

SECTION 1133. Laboratories shall not be approved to do premarital and prenatal tests if they advertise the performance of these tests in magazines, newspapers, directories, circulars, etc., commonly read by the lay public.

SECTION 1134. Failure to comply with the provisions of the Clinical Laboratory Act, or the Premarital and Prenatal Laws and Regulations pertaining thereto shall be cause for revocation of approval to perform premarital and prenatal tests and recall of all outstanding laboratory report books and marriage health certificates.

DR. E. T. BLOOMQUIST APPOINTED NEW TUBERCULOSIS BUREAU CHIEF

Dr. E. T. Bloomquist, on loan from the U. S. Public Health Service, has replaced Dr. Robert Anderson as acting chief of the Bureau of Tuberculosis.

Dr. Bloomquist comes to this department from the Oregon State Board of Health where he was director of the tuberculosis control section. Dr. Anderson has been assigned to the Washington, D. C. offices of the Public Health Service. He will become assistant chief of the tuberculosis control office of that organization.

POSITIVE PLAGUE SPECIMENS FOUND

Three pools of rodent parasites collected by State survey crews in October were positive for plague.

Specimens were collected in Kern and El Dorado Counties.

FELLOWSHIPS IN HEALTH EDUCATION OFFERED BY USPHS

Fellowships for graduate study in health education are again being offered to qualified persons by the United States Public Health Service.

The fellowships, leading to a master's degree in public health, are made possible by grants from the National Foundation for Infantile Paralysis for the academic year 1947-48.

The United States Public Health Service announces that this is probably the last year in which these fellowships will be offered. It is therefore important that an exceptionally well qualified group be recruited.

Eligibility is open to all United States citizens of sound health, ages 22-40. Applicants must hold a bachelor's degree from a recognized college or university and must be able to meet the entrance requirements of the graduate school of public health of their choice. These requirements usually include courses in the biological sciences, sociology, and education. Training in public speaking, journalism, and psychology, and work in public health are also considered desirable qualifications.

The training will consist of one academic year of graduate study in an accredited school of public health, plus three months of supervised field experience in community health education.

Stipends include tuition expenses and $100 per month for the entire period. Travel expenses for field training are provided.

HOW TO APPLY

Application forms may be obtained from the Surgeon General, United States Public Health Service, Washington 25, D. C. The completed application must be accompanied by two prints of recent photographs of the applicant; an official transcript of college credits; and a 500 word statement explaining why the applicant is interested in entering the field of health education.

Employees of state and local health departments are not eligible since federal funds for scholarships are available for their training from the State Department of Public Health.

Applications must be completed and on file in the Surgeon General's office before March 15, 1947 to be considered.

NEW NURSING CONSULTANT

The Bureau of Public Health Nursing has acquired the services of Helen Kienzle, who will act as a district nursing consultant for the bureau. Miss Kienzle received her master's degree in public health from Columbia Teachers' College. She has, until recently, been serving as supervising nurse in the Van Buren County Health Department, Michigan.

MORBIDITY REPORTS

SELECTED DISEASES—CIVILIAN CASES

Total Cases for October and Total Cases for January Through October, 1946, 1945, 1944 and 5 Year Median (1941-1945)

Selected diseases	Current month: October				Cumulative: January through October			
	1946	1945	1944	5-yr. median 1941-1945	1946	1945	1944	5-yr. median 1941-1945
Chickenpox	919	811	1,000	946	21,708	40,311	30,432	36,304
Coccidioidal granuloma	8	1	3	----	35	31	27	----
Conjunctivitis — acute infectious of the newborn (Ophthalmia Neonatorum)	2	4	3	----	45	20	30	----
Diphtheria	97	159	92	115	997	1,008	951	851
Dysentery, bacillary	45	24	49	----	205	238	378	----
Encephalitis, infectious	18	36	18	----	139	263	71	----
Epilepsy	151	126	91	----	1,293	1,334	1,275	----
Food poisoning	93	101	92	----	387	447	543	----
German measles	163	259	204	----	11,834	10,785	14,259	----
Influenza, epidemic	32	59	55	59	5,235	650	10,954	3,110
Jaundice, infectious	7	25	17	----	157	208	279	----
Malaria	15	54	13	17	534	200	109	119
Measles	394	941	632	632	61,788	31,505	66,294	31,505
Meningitis, meningococcic	28	33	47	33	472	585	882	585
Mumps	498	1,344	1,131	1,257	17,681	33,636	27,810	27,810
Pneumonia, infectious	112	151	242	223	1,966	2,885	3,601	2,885
Poliomyelitis, acute anterior	306	180	61	68	1,976	674	364	364
Rabies, animal	20	32	64	55	346	523	806	523
Rheumatic fever	60	97	31	----	591	641	465	----
Scarlet fever	519	929	584	554	6,304	11,735	8,166	5,470
Septic sore throat	47	----	1	----	77	----	1	----
Smallpox	----	----	----	0	8	4	20	7
Tuberculosis:								
Pulmonary	737	783	658	584	7,189	6,886	6,851	66,224
Other forms	43	61	42	41	448	509	411	389
Typhoid fever	23	13	14	14	136	116	231	123
Typhus fever	13	17	3	----	57	40	26	----
Undulant fever	35	25	24	25	257	222	267	222
Whooping cough	327	697	352	697	3,690	12,996	3,855	12,996
Venereal disease:								
Chancroid	60	26	24	----	458	216	260	----
Gonococcus infection	3,741	3,025	1,700	1,521	28,805	23,408	16,514	13,659
Granuloma Inguinale	8	4	2	----	35	38	20	----
Lymphogranuloma venereum	27	17	31	----	185	206	197	----
Syphilis	2,699	2,356	2,009	2,009	21,627	23,264	22,772	22,772

THREE STATE DEPARTMENT MEMBERS GAIN POSITIONS ON APHA COUNCIL

State Department of Public Health representation on the governing council of the American Public Health Association increased to three during the recent APHA convention in Cleveland.

Dr. Wilton L. Halverson, director, retained his position on the council while Dr. Robert Dyar, chief of the Division of Preventive Medical Services, and Ann W. Haynes, chief of the Bureau of Health Education, became new members of the executive body.

Dr. Dyar took his seat on the council following a general election by APHA fellows. Mrs. Haynes gained her place by virtue of being elected vice chairman of the public health education section.

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